Butler University
Department of
Recreation Personal
Training Medical
Release Form

Date / /

Dear
Doctor:

Your patient,_____, wishes to start a personalized training program.

If your patient is taking medications that will affect their heart rate response to exercise or should limit certain types of movement, please indicate the manner of the effect (raises, lowers, or has no effect on the heart-rate response) and movement limitations:

Type of medication
_____ Effect
_____
__

Please identify any movement or general recommendations or restrictions that are appropriate for your patient regarding exercise:
_____
_____
_____
_____
_____
_____

Thank
you.

Sincerely,

Natalie Szocs Fitness
Coordinator Office of
Recreation and Wellness Butler
University 530 W. 49th St.
Indianapolis, IN 46208-3485 (P)
317.940.6121 (F) 317.940.6153

_____ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Signed _____ Date / / Phone ( ) -